STATE OF MICHIGAN
IN THE SUPREME COURT

ON APPEAL FROM THE COURT OF APPEALS AND
THE WORKER'S COMPENSATION APPELLATE COMMISSION

AUTO-OWNERS INSURANCE COMPANY,

Plaintiff-Appellant,

v

AMOCO PRODUCTION COMPANY,

Defendant-Appellee.

Supreme Court Case No. 119403
Associated No. 119410

Court of Appeals
Case No. 223572

WCAC No. 95-000532

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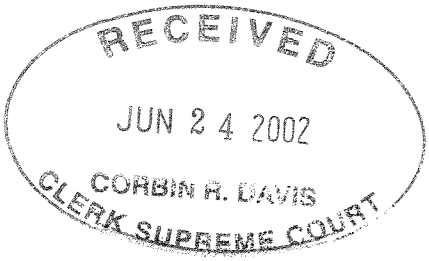
BRIEF OF APPELLANT AUTO-OWNERS INSURANCE COMPANY

Oral Argument Requested



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STATEMENT OF THE BASIS OF JURISDICTION

The Court of Appeals rendered its opinion in this matter on May 27, 2001. Pursuant to MCR 7.302(C)(2)(a), plaintiff-appellant Auto-Owners Insurance Company filed an application for leave to appeal on June 7, 2001. The application for leave to appeal of Auto-Owners was granted on April 30, 2002.

STATEMENT OF QUESTIONS INVOLVED

I. Where an employee is injured in a motor vehicle accident and the workers' compensation insurer denies coverage claiming that the accident was not work related and the no-fault insurer pays the reasonable medical expenses of the employee and the injury is later determined to be work related, is the no-fault insurer equitably subrogated to the statutory claim of the employee to be reimbursed for reasonable medical expenses not limited by the workers' compensation fee schedule?

- The Magistrate said: "No."
- The WCAC said: "No."
- The Court of Appeals said: "No."
- Plaintiff-Appellant says: "Yes."
- Defendant-Appellee says: "No."

STATEMENT OF FACTS

On January 30, 1994, Leroy Smithingell was injured in an accident involving his motor vehicle at his place of work. 20a. The accident occurred on the employer's premises but before regular working hours. *Id.* Defendant-appellee Amoco Production Company was Smithingell's employer and self-insured workers' compensation insurer. *Id.* Amoco denied Smithingell's application for workers' compensation insurance benefits arising out of the injury on the grounds that the injury was not work-related. 2a. Smithingell then filed an application for benefits with Auto-Owners, his no-fault insurer. Auto-Owners paid Smithingell's reasonable medical expenses, 20a, and thereafter filed an application for hearing with the Bureau of Workers Disability Compensation. 1a. Auto-Owners requested the Bureau to determine liability and determine rights and stated: "Auto-Owners as first-party no-fault carrier has paid medical and wage loss benefits to Leroy Smithingell. However, the accident occurred while Mr. Smithingell was in the course of employment with Amoco Production Company. Thus, Amoco is liable for all benefits paid and future benefits incurred." *Id.*

Trial before the workers' compensation magistrate was held on April 19, 1995. The magistrate issued his opinion on May 1, 1995. The magistrate found that the injury was work-related and that Auto-Owners was entitled to reimbursement for medical benefits paid by Auto-Owners. 21a. However, he limited Auto-Owners'

reimbursement to the amounts provided in the workers' compensation cost containment rules. 22a.

The parties cross-appealed and the Workers' Compensation Appellate commission affirmed the magistrate's decision in its entirety. 23a. Auto-Owners filed an application for leave to appeal to the Court of Appeals. In lieu of granting leave, the Court of Appeals remanded to the Appellate Commission for further consideration. 29a. The Appellate Commission reaffirmed its prior opinion on February 22, 1999. 30a. Auto-Owners again filed an application for leave to appeal. Again, in lieu of granting leave, the Court of Appeals remanded for a second time for "further consideration of whether the cost containment rules limit reimbursement under the circumstances of this case." 35a. The Appellate Commission again affirmed its prior decisions on October 22, 1999. 36a. Again, Auto-Owners filed an application for leave to appeal which was granted. 40a. On March 27, 2001, in a published opinion, the Court of Appeals affirmed the decision of the Appellate Commission on application of the cost containment rules. 41a. The Court of Appeals remanded to the Appellate Commission for a determination of the amount owing for reimbursement. Appellee Amoco filed a petition for rehearing with regard to the remand on April 16, 2001. Amoco's motion for rehearing was denied on May 17, 2001. 46a.

Plaintiff-appellant Auto-Owners filed an application for leave to appeal to the Michigan Supreme Court pursuant to 7.302(C)(2)(c). An order granting leave to appeal was entered April 30, 2002.

ARGUMENT

I. Under *Hartford Accident & Indemnity Co V Used Car Factory, Inc.*, 461 Mich 210; 600 NW2d 630 (1999), Auto-Owners Had a Valid Equitable Subrogation Claim Against Amoco for the Reimbursement of the Full Amount of the Reasonable Medical Expenses Paid by Auto-Owners and the Worker's Compensation Bureau Had Jurisdiction to Grant Such Relief Pursuant to § 841 of the WDCA

Standard of Review: An inquiry into the nature, scope and elements of a remedy is in sum a question of law to be reviewed de novo. *Hartford Accident & Indemnity Co v Used Car Factory, Inc.*, 461 Mich 210, 215, n.5; 600 NW2d 630, 633, n.5 (1999). The Court reviews questions of law involved in any final order of the WCAC under a de novo standard of review. *Mudel v Great Atlantic and Pacific Tea Co*, 462 Mich 691, 697, n.3; 614 NW2d 607, 610, n.3 (2000).

Section 315(1) of the Michigan Worker's Disability Compensation Act ("WDCA"), MCL 418.315(1), provides in relevant part: "The employer shall furnish or cause to be furnished to an employee who receives a personal injury arising out of and in the course of employment, reasonable medical, surgical and hospital services and medicine or other attendance or treatment recognized by the laws of this state as legal when they are needed..."

Section 315 was amended in 1981 by the addition of subsection (2) which provides in relevant part:

> Except as otherwise provided in subsection (1), all fees and other charges for any treatment or attendance, service, devices, apparatus, or medicine under subsection (1), are subject to rules promulgated by the Bureau of Worker's Compensation pursuant to the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.201 through 24.328. The rules promulgated shall establish schedules of maximum charges for the treatment or attendance, service, devices, apparatus, or medicine, which schedule shall be annually revised. *A health facility or health care provider shall be paid either its usual and customary charge for the treatment or attendance, service, devices, apparatus, or medicine or the maximum charge established under the rules, whichever is less.* [Emphasis supplied]

Although subsection (2) was enacted in 1981, the fee schedules required by the act were not in fact adopted until 1989. See Kaser, *The Worker's Compensation Health Care Services Rules*, 69 MBJ 278 (1990).

A health care provider who provides services to a person insured under the WDCA must accept the amounts set forth in the administrative rules as payment in full and may not bill the employee the difference between the provider's customary charge and the maximum allowable payment established by the rules. "The provider shall not bill the employee for any amount for health care services provided for the treatment of a covered injury or illness when that amount is disputed by the carrier pursuant to its utilization review program or when that amount exceeds the maximum

allowable payment established by these rules." 2000 AACS R418.10105 (formerly 1988 AACS R418.114).

However, where an employer denies a claim for workers' compensation medical benefits and the employee pays for her own medical expenses, and it is later determined that the injury is work related, the employer is required to reimburse the employee for the reasonable expense paid by the employee. "If the employer fails, neglects, or refuses [to furnish or cause to be furnished reasonable medical, surgical and hospital services, etc.], the employee shall be reimbursed for the reasonable expenses paid by the employee, or payment may be made on behalf of the employee to persons to whom the unpaid expenses may be owing, by order of the worker's compensation magistrate." MCL 418.315(1), MSA 17.237(315)(1); *Auto-Owners Ins Co v Amoco Production Co*, 245 Mich App 171, 176 (2001). The workers' compensation rules specifically provide that an employee's right of reimbursement is determined by what the employee paid, not by the fee schedule under the workers' compensation health care services rules. 2000 AACS R418.10104 (formerly 1991 AACS, R418.2102): "Notwithstanding any other provision of these rules, if an employee has paid for a health care service and at a later date a carrier is determined to be responsible for the payment, then the employee shall be fully reimbursed by the carrier." For purposes of this case, it is significant that § 315(1) and R418.10105 implicitly recognize that

where the worker's compensation carrier disputes coverage, the health care provider is not prohibited from charging the employee its full reasonable and customary charge unlimited by the fee schedule.

Section 3109 of the Michigan No-Fault Act, MCL 500.3109, provides at subsection (1): "Benefits provided or required to be provided under the laws of any state or the federal government shall be subtracted from the personal protection insurance benefits otherwise payable for the injury." Where an employee is injured in a motor vehicle accident arising out of his employment and he is covered under both worker's compensation insurance and no-fault insurance, the Michigan courts have uniformly held that worker's compensation benefits come within the ambit of "benefits provided or required to be provided under the laws of any state" as that language is used in § 3109(1) of the no-fault act. *Joiner v Michigan Mutual Ins Co*, 161 Mich App 285, 291; 409 NW2d 808 (1987). "In a situation where a worker is injured in a motor vehicle accident in the course of his employment, worker's compensation benefits must be subtracted from the no-fault recovery. The purpose of § 3109(1) is to make the no-fault insurer only secondarily liable...." *Id.*

Where an injury is covered under both worker's compensation insurance and no-fault insurance, a provider may not bill the no-fault carrier for the excess of the provider's customary fee over

the amount set by the worker's compensation fee schedule. For a no-fault insurer to be liable for a medical charge, the charge must be a charge "incurred" by the injured person. MCL 500.3107(1)(a); *Bombalski v Auto-Club Ins Ass'n*, 247 Mich App 536, 541 (2001). Where an injured party bears no liability for the full medical service amounts customarily charged by his health care providers, he has not incurred these full charges. 247 Mich App at 543. Incurred medical expenses are limited to those amounts actually paid or that the no-fault insured remains legally obligated to pay. *Id.*

Under MCL 418.315(2) and 2000 AACS R418.10105, where worker's compensation coverage is not disputed, the provider may not bill the employee for any amount which exceeds the maximum allowable payment established by the worker's compensation fee schedules. Therefore, where worker's compensation coverage is not disputed, the employee has not incurred the excess charge and the excess charge is, therefore, not an allowable expense under § 3107(1)(a) of the no-fault act. See also *Dean v Auto-Club Ins Ass'n*, 139 Mich App 266 (1984). In *Dean*, the Court of Appeals held that where the health care provider contractually agreed to accept payment under the Blue Cross Blue Shield fee schedule as payment in full, the no-fault carrier was not liable to the health care provider for the difference between the provider's customary charge and the amount set in the BCBS fee schedule. "To seek remuneration in excess of

the prescribed reimbursement rate for services rendered to 'no-fault patients' collides directly with § 3157 [of the Michigan No-Fault Act]." 139 Mich App at 274.

Finally, where an employee is injured in a motor vehicle accident and the workers' compensation insurer denies coverage, the no-fault insurer is required to pay medical expenses on behalf of the employee so long as the employee is making reasonable efforts to obtain workers' compensation coverage that might be available. *Specht v Citizens Ins Co of America*, 234 Mich App 292, 295-296 (1999). Where a health care provider is not otherwise limited by contract or statute in the amount that may be charged to an injured person, the only limitation applicable to a provider's customary charges to a person injured in a motor vehicle accident and his or her no-fault insurer is that the charge may not exceed a reasonable charge. MCL 500.3107 and 3157; *Mercy Mt. Clemens Corp v Auto-Club Ins Ass'n*, 219 Mich App 46, 51 (1996).

In the instant case, the charges by the health care providers to the employee were in excess of the amounts allowed under the workers' compensation fee schedule but were not in excess of a reasonable charge. Because Amoco as the self-insured worker's compensation insurer denied coverage, Auto-Owners was required under *Specht* to pay the reasonable medical expenses incurred by the employee.

In *Hartford Accident and Indemnity Co v Used Car Factory, Inc.*, 461 Mich 210, 218; 600 NW2d 630 (1999), this Court held: "A non-volunteer who is required to pay a debt that is primarily owed by a third person is equitably subrogated to the rights of the subrogee [sic][1]." In the instant case, it is undisputed that Auto-Owners was a non-volunteer. It is undisputed that Auto-Owners was required to pay a debt that was primarily owed by Smithingell. It is undisputed that the employee's reimbursement rights are not limited by the workers' compensation fee schedule, but that the employee "shall be reimbursed reasonable expenses." MCL 418.315(1).

The Court of Appeals held that equitable subrogation did not apply in the instant case because MCL 418.315(1) requires reimbursement in a reasonable amount only when the employee herself pays the medical expenses and here, the medical expenses were paid

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[1]It is clear that the use of "subrogee" in this quotation is a typographic error for "subrogor." Black's Law Dictionary, 6th Ed., defines "subrogee" as "A person who is subrogated; one who succeeds to the rights of another by subrogation." The same authority defines "subrogor" as "The person who substitutes another for himself; one who performs the subrogation." Thus, the cited sentence should properly read: "A non-volunteer who is required to pay a debt that is primarily owed by a third person is equitably subrogated to the rights of the subrogor." For the proper usage, see *Commercial Union Ins Co v Medical Protective Co*, 426 Mich 109, 117; 393 NW2d 479 (1986): "Equitable subrogation is a legal fiction through which a person who pays a debt for which another is primarily responsible is substituted or subrogated to all the rights and remedies of the other. It is well-established that the subrogee acquires no greater rights than those possessed by the subrogor, and that the subrogee may not be a 'mere volunteer.'"

by Auto-Owners on behalf of the employee. *Auto-Owners*, 245 Mich App at 177.

An identical argument with regard to the Wrongful Death Act was rejected by the Court of Appeals in *Citizens Ins Co of America v Buck*, 216 Mich App 217; 548 NW2d 680 (1996). The approach in *Buck* was approved and applied by this Court in *Used Car Factory*. In *Buck*, the plaintiff was an automobile insurer who paid a large uninsured motorist claim on behalf of its insured who had been killed in an accident caused by an uninsured motorist. The insurer then brought an equitable subrogation claim against the tortfeasor. The tortfeasor answered that since the victim had died, any tort claim was governed by the requirements of the Wrongful Death Act at MCL 600.2922(2); MSA 27A.2922(2). Since the Wrongful Death Act required that a wrongful death action be brought by the personal representative and since the insurer was not the personal representative, therefore, the insurer's equitable subrogation action was barred. The trial court granted the defendant's motion for summary disposition.

The insurer appealed and the Court of Appeals reversed. The Court of Appeals held, 216 Mich App at 225:

> Although, superficially, it may appear that plaintiff Citizens Insurance Company of America here seeks to pursue a surrogate form of action for wrongful death acquired by its payment to decedent's estate pursuant to the provisions of its no-fault policy, including the optional uninsured motorist coverage decedent's parents purchased, this outward appearance is deceiving. Plaintiff is not attempting to prosecute a

wrongful death action by way of assignment but, rather, is pursuing equitable subrogation.

The court further held, 216 Mich App at 226: "An action for equitable subrogation is independent of the wrongful death act and thus is not subject to the requirements and preconditions of a wrongful death action." This holding was cited with approval by this Court in *Used Car Factory*.

The Worker's Compensation Bureau has concurrent jurisdiction with the circuit courts to determine and grant relief on reimbursement claims involving worker's compensation. *Ptak v Pennwalt Corp*, 112 Mich App 490 (1982), involved a situation where the worker's compensation carrier denied coverage and the injured worker sought coverage from his health insurer, Blue Cross Blue Shield. The worker filed a petition for hearing with the Bureau of Worker's Compensation and BCBS filed an appearance and motion to intervene and seek reimbursement. The Worker's Compensation Appeal Board held that BCBS had no standing to seek the requested relief. The Court of Appeals reversed and held that the bureau did have jurisdiction of the reimbursement claim and that BCBS had standing to assert the claim before the bureau. The Court of Appeals held, 112 Mich App at 494:

> Section 841 of the compensation act provides:
>
> > "Any controversy concerning compensation shall be submitted to the bureau and all questions arising under this act shall be determined by the bureau. The director shall be deemed to be an interested party in all workmen's compensation

> cases in questions of law." MCL 418.841; MSA 17.237(841).
>
> Further, § 847 states:
>
> > "Upon the filing with the bureau by any party in interest of an application in writing stating the general nature of any claim as to which any dispute or controversy may have arisen, the director shall set the case for hearing and shall designate a hearing referee to hear the case." MCL 418.847; MSA 17.237(847).
>
> Under *Joliff* [*v American Advertising Distributors, Inc.*, 49 Mich App 1 (1973)], and *Epps* [*v Mercy Hospital*, 69 Mich App 1 (1979)], it is clear that BCBS is entitled to reimbursement for work-related benefits already paid to petitioner. The "voluntary" nature of any payments to an injured employee does not affect this right to reimbursement. The reimbursement, however, is dependent upon a determination of whether petitioner's injury arose during the course of his employment and whether the payments made by BCBS were reasonable and necessary. Such issues fit squarely within the jurisdictional authority granted to the compensation bureau under MCL 418.841; MSA 17.237(841).

"The bureau has jurisdiction over any controversy concerning compensation." *Russell v Welcor, Inc.*, 157 Mich App 351, 354 (1987), citing MCL 418.841 and 847.

The Court of Appeals later held in *Westchester Fire Ins Co v Safeco Ins Co*, 203 Mich App 663 (1994), that although the bureau had exclusive jurisdiction to decide whether injuries suffered by an employee were in the course of employment, the jurisdiction of the bureau to determine other controversies relating to reimbursement was concurrent with the circuit courts. 203 Mich App at 670.

Under § 841 of the WDCA, the worker's compensation bureau had concurrent jurisdiction to determine the equitable subrogation claims involving payment by a third-party of medical expenses which were later determined by the bureau to be work-related. However, since the bureau's authority arises under § 841, it is not restricted to the statutory categories set forth in § 315. Although § 315(1) provides only that the employee has a reimbursement action unlimited by the fee schedule, Auto-Owners' claim was not a claim under § 315(1). Auto-Owners' claim was a claim for equitable subrogation under § 841 and was thus "not subject to the requirements and pre-conditions" of a claim under § 315(1). See *Buck*, 216 Mich App at 226; *Used Car Factory*, 461 Mich at 215-216.

II. Since Auto-Owners' Claim Was an Equitable Subrogation Claim and Not a Claim Under § 315(1), the Court of Appeals Incorrectly Applied the Doctrine of Deference to an Administrative Construction of a Statute

Standard of Review: An inquiry into the nature, scope and elements of a remedy is in sum a question of law to be reviewed de novo. *Hartford Accident & Indemnity Co v Used Car Factory, Inc.*, 461 Mich 210, 215, n.5; 600 NW2d 630, 633 (1999). The Court reviews questions of law involved in any final order of the WCAC under a de novo standard of review. *Mudel v Great Atlantic and Pacific Tea Co*, 462 Mich 691, 697, n.3; 614 NW2d 607, 610 (2000).

In this matter, the fundamental error of the Court of Appeals as well as the Appellate Commission and the magistrate, was in

viewing an equitable subrogation claim as a statutory claim under § 315(1). Equitable subrogation is a flexible elastic doctrine of equity and its application should and must proceed on a case by case analysis characteristic of equity jurisprudence. *Used Car Factory*, 461 Mich at 215. Hence, the reliance by the Court of Appeals on the deference to be accorded to an administrative agency in construction of a statute is misplaced. While the Workers' Compensation Bureau has exclusive jurisdiction to decide whether injuries suffered by an employee were in the course of employment, *Westchester Fire Ins Co v Safeco Ins Co*, 203 Mich App 663, 669; 513 NW2d 212 (1994), the Bureau has an additional jurisdiction under MCL 418.841 over "any controversy concerning compensation." *Ptak v Pennwalt*, 112 Mich App 490, 493 (1982). This additional jurisdiction is concurrent with the jurisdiction of the circuit courts. *Westchester Fire*, 203 Mich App at 670.

Where this concurrent jurisdiction extends to claims, like the instant claim, which traditionally sound in equity, the grounds typically stated for the doctrine of deference to administrative construction of a statute do not apply. Indeed, it may be reasonably argued that in the application of equitable remedies, the courts have expertise superior to that of administrative agencies such as the WCAC.

Appellee makes the same error as the Court of Appeals when appellee argues that the fundamental issue involved is the meaning

of the word "employee" as used in § 315(1) of the WDCA. This makes appellee's task easy since it cannot be reasonably argued that the term "employee" as used in the WDCA reasonably includes a no-fault insurer. The error in appellee's argument can be seen by comparing the instant case to *Buck, supra*. According to appellee's argument, the fundamental issue in *Buck* should have been whether the term "personal representative of the estate of the deceased person" as used in subsection 2 of the Michigan Wrongful Death Act, MCL 600.2922(2), included a no-fault insurer.

The Court of Appeals in *Buck* conceded that the no-fault insurer was not the "personal representative of the estate of the deceased person." Rather, the Court of Appeals held: "An action for equitable subrogation is independent of the wrongful death act and thus is not subject to the requirements and pre-conditions of a wrongful death action." *Buck*, 216 Mich App at 226.

Similarly, in the instant case, the issue is not whether Auto-Owners is an employee as defined by the act. The issue is whether Auto-Owners has an claim for equitable subrogation independent of § 315(1) of the act.

III. Under *Dean v Auto-Club Ins Ass'n*, 139 Mich App 266 (1984), and *Bombalski v Auto-Club Ins Ass'n*, 247 Mich App 536 (2001), Auto-Owners Would Not Have Been Liable for the Excess of the Provider's Reasonable and Customary Charge over the Amounts Allowed in the Worker's Compensation Fee Schedule, but for the Fact That Amoco Wrongly Denied Worker's Compensation Coverage in the First Instance

Standard of Review: The quest of whether the decision of the Court of Appeals in the instant case conflicts with the prior decision of the Court of Appeals in *Dean* is a question of law. The Court reviews questions of law involved in any final order of the WCAC under a de novo standard of review. *Mudel v Great Atlantic and Pacific Tea Co*, 462 Mich 691, 697, n.3; 614 NW2d 607, 610 (2000).

The Court of Appeals made a third error of law which apparently influenced its decision in the instant case. The ruling of the Court of Appeals appears to assume that even though, when worker's compensation coverage is undisputed, a health care provider is prohibited by law from charging a covered employee or workers' compensation insurer more than the amount of the fee schedule, the health care provider may obtain amounts in excess of the fee schedule where a no-fault insurer is also involved. *Auto-Owners*, 245 Mich App at 178.

In a case involving the Blue Cross Blue Shield ("BCBS") fee schedule, this identical position was rejected by the Court of Appeals. *Dean v Auto-Club Ins Ass'n*, 139 Mich App 266 (1984). In *Dean*, a chiropractor entered into a participation agreement with

BCBS whereby the provider agreed to accept less than his customary charges for patients covered by BCBS. Where the same patient was also covered by no-fault insurance, however, the chiropractor billed the no-fault insurer for the difference between his customary rate and the BCBS rate. The provider's position was rejected by the Court of Appeals. The Court held, *Dean*, 139 Mich App at 274-275:

> The lower court stated that § 3157 had no application "in that the customary fees charged by a physician are not at issue when the plaintiffs have entered into a provider contract with BCBSM". Section 3157 is, however, instructive on this issue. It represents the policy of this state that the existence of no-fault insurance *shall not* increase the cost of health care. In the context of the instant case, plaintiffs must accept the reimbursement rate prescribed by BCBSM for services rendered to patients whose injuries do *not* arise from situations covered by no-fault insurance. See MCL 550.1502; MSA 24.660(502). To seek remuneration in excess of the prescribed reimbursement rate for services rendered to "no-fault patients" collides directly with § 3157. This conclusion results irrespective of the reasonableness of the fees sought to be recovered, since plaintiffs seek such remuneration solely on the basis of the existence of no-fault insurance.
>
> We do not address plaintiffs' contentions that defendant is not a third-party beneficiary to their provider contract with BCBSM. Nor do we address defendant's argument that its no-fault insurance policies incorporate such agreement by reference. Our decision is not based on the construction of either plaintiffs' provider contract or defendant's insurance policies. Rather, we hold, as a matter of public policy, that the relief sought by plaintiffs is precluded by the intent and spirit of the no-fault act.

Dean was followed in *Thomas v State Farm*, 159 Mich App 372, 374; 406 NW2d 300 (1987); *Hofmann v Auto-Club Ins Ass'n*, 211 Mich

App 55, 62; 535 NW2d 529 (1995); and *Bombalski v Auto-Club Ins Ass'n*, 247 Mich App 536 (2001), and cited with approval in *Federal Kemper Ins Co, Inc. v Health Ins Administration, Inc.*, 424 Mich 537, 550; 383 NW2d 590 (1986).

Similarly, as discussed above in section one of this brief, the recent decision in *Bombalski* rejects the implied holding of the Court of Appeals in the instant case that, where an injured party is covered both by worker's compensation insurance and by no-fault insurance, the no-fault insurer may be liable to the health care provider for the difference between the provider's customary fee and the maximum fee set by the worker's compensation fee schedules. Where worker's compensation coverage is undisputed, the employee is not liable to the health care provider for the excess between the provider's customary charge and the charge as limited by the worker's compensation fee schedule. MCL 418.315(1); 2000 AACS R418.10105. Therefore, the injured employee has not incurred the excess charge and the excess charge is not an allowable expense under § 3107(1)(a) of the no-fault act. *Bombalski*, 247 Mich App at 543.

In this connection, the Court of Appeals in the instant case was apparently misled by its misreading or misunderstanding of the holding in *Munson Medical Center v Auto-Club Ins Ass'n*, 218 Mich App 375, 390; 554 NW2d 49 (1996). *Munson* was not a reimbursement case and there was no claim in *Munson* that the insured was covered

under workers' compensation insurance. What happened in *Munson* was that Auto-Club was applying the workers' compensation fee schedule in no-fault cases that did not involve workers' compensation issues. Auto-Club based this approach on an interpretation of MCL 500.3157 of the Michigan No-Fault Act. The Court of Appeals rejected Auto-Club's interpretation of § 3157 and held that the use by Auto-Club of the workers' compensation fee schedule to limit payment to the provider in a case that did not involve workers' compensation was improper.

However, there is no indication that the *Munson* Court intended to overrule *Dean*. *Munson* cannot be reasonably interpreted to hold, contrary to *Dean*, that in cases involving workers' compensation, the health care provider can bill the workers' compensation insurer the fee schedule amount and, in addition, bill the no-fault insurer the excess of the provider's "customary" fee over the workers' compensation fee schedule fee. This practice was rejected in *Dean* and *Bombalski*, and the *Munson* opinion was directed to a wholly different issue.

The inapplicability of *Munson* to the excess charge issue was fully discussed by the Court of Appeals in *Bombalski*, 247 Mich App at 545, n.3 as follows:

> We note that plaintiff misplaces his reliance on *Munson Medical Center v Auto Club Ins. Ass'n*, 218 Mich App 375, 554 NW2d 49 (1996), and *Hofmann v Auto Club Ins Ass'n*, 211 Mich App 55, 535 NW2d 529 (1995). The no-fault insurer in each of these cases sought to limit the amounts it paid to medical providers according to fee

> schedules utilized by other insurance companies or under the Worker's Disability Compensation Act. *Munson, supra* at 378; *Hofmann, supra* at 114. Both cases involved the interpretation of the term "customary charges" within MCL §§ 500.3157. This Court in each case concluded that in situations where no other health or accident coverage existed, the no-fault insurer could not refer to amounts paid by other insurance companies, Medicare, Medicaid or worker's compensation as a benchmark for determining the amounts of its own payments of customary charges under § 3157. This Court observed that while other fee schedules were limited by contract or various federal and state statutes, the no- fault statute governed no-fault carriers' payments and required them to pay amounts customarily charged in cases not involving insurance. *Munson, supra* at 383-385,; *Hofmann, supra* at 113-114.
>
> The present case plainly involves a different statutory section and term and is further distinguishable on the basis that here other insurance coverage does exist and has afforded full satisfaction of the medical providers' bills.

The Court of Appeals in the instant case was apparently under the impression that Auto-Owners was overreaching in that absent its claim for equitable subrogation, and absent the initial dispute over the existence of worker's compensation coverage, Auto-Owners would have been liable for the difference between the workers' compensation rate and the provider's customary charge. Therefore, the Court reasoned, Auto-Owners was no worse off than it would have been had the workers' compensation insurer properly accepted the claim in the first instance. This is incorrect. If the workers' compensation insurer had paid the claim as it was legally bound to do, under *Dean* and *Bombalski*, the provider could not have collected an additional amount from Auto-Owners. The net result of the decision in the instant case is that the party which wrongfully

avoids its obligation escapes without penalty, whereas the party which honors its obligation to pay pending resolution of the dispute is penalized.

IV. The Decision of the Court of Appeals Conflicts with the Policy Consistently Expressed by the Courts of this State that in Cases of Priority Disputes, No-Fault Insurers Should Pay the Claim and Resolve the Dispute Later Between the Insurers.

Standard of Review: Whether the decision of the Court of Appeals in the instant case conflicts with the policy expressed by the Court of Appeals in numerous other cases that in cases of priority disputes, no-fault insurers should pay the claim and resolve the dispute later between the insureds is a question of law. The Court reviews questions of law involved in any final order of the WCAC under a de novo standard of review. *Mudel v Great Atlantic and Pacific Tea Co*, 462 Mich 691, 697; 614 NW2d 607, 610 (2000).

Fourthly, the decision of the Court of Appeals in the instant case is contrary to the policy consistently expressed by the courts of this state since the passage of the Michigan No-Fault Act in 1973. This policy is summarized in Logeman, *Michigan No-Fault Automobile Cases*, 2d Ed., § 6.28, p 6-28:

> It is important to remember that the underlying purpose of the No-Fault Act is to provide a system for paying no-fault benefits promptly. When there is a bona fide priority dispute, the courts have encouraged insurers to pay the benefits to the claimant and resolve priority disputes among themselves. If an insurer does not do so, it may be responsible for a pro rata portion of the plaintiff's actual attorney fees, even if it prevails on the priority question. *Kalin v DAIIE*, 112 Mich App 497,

> 316 NW2d 467 (1982). The rationale behind this reasoning is that it is unfair that an injured person must wait several years for benefits to be paid while the insurers settle their disputes. Further, penalty interest (see § 6.33) will clearly be owing regardless of whether the insurer denied the claim in good faith in a priority dispute. *Darnell v Auto-Owners Ins Co*, 142 Mich App 1, 369 NW2d 243 (1985); *Bach v State Farm Mutual Automobile Ins Co*, 137 Mich App 128, 357 NW2d 325 (1984). See also *Clute* [*v General Accident Assurance Co of Canada*, 177 Mich App 411, 442 NW2d 689 (1989)], in which the court, citing *Darnell, Bach,* and *Kalin*, stated that where the issue is priority, not coverage, the failure of plaintiff's own insurer to pay benefits should be deemed unreasonable.

The holding of the Court of Appeals in the instant case subjects no-fault insurers to inequitable pressures which violate concepts of basic fairness. Where a workers' compensation carrier denies coverage, the policy of the no-fault act and the courts of this state clearly indicate that a no-fault carrier should pay the benefits and resolve its dispute with the workers' compensation carrier, not with the injured employee. *Specht*, 234 Mich App at 295. This policy is enforced by the penalty interest and attorney fee provisions of the no-fault act which may be applied against the no-fault carrier if the carrier fails to step in. On the other hand, if it is ultimately determined that the workers' compensation carrier wrongfully denied coverage, the no-fault carrier is left without the possibility of recoupment from the workers' compensation carrier for medical expense payments made by the no-fault carrier in excess of the workers' compensation fee schedule. These excess amounts would not have been owing had the workers'

compensation carrier complied with its statutory and contractual obligations to acknowledge coverage in the first instance.

On the other side of the coin, the initial decision of the workers' compensation carrier whether to accept or deny coverage becomes risk free. The workers' compensation carrier will pay no greater amount as a result of its initial wrongful denial of coverage. The economic incentive to the workers' compensation carrier to deny coverage becomes irresistible. In case of a wrong decision, it is the no-fault carrier, not the workers' compensation carrier, that pays the penalty. This result is contrary both to concepts of basic fairness and to free market economic theory.

V. The Decision of the Court of Appeals Exalts Form over Substance in That Auto-Owners Could Have Asserted an Equitable Reimbursement Action Directly Against the Employee under *MEEMIC v Morris*, 460 Mich 180 (1999) and it Is Undisputed That a Third-Party Claim by the Employee Against Amoco Would Not Have Been Limited to Fee Schedule Amounts

Standard of Review: An inquiry into the nature, scope and elements of a remedy is in sum a question of law to be reviewed de novo. *Hartford Accident & Indemnity Co v Used Car Factory, Inc.*, 461 Mich 210, 215, n.5; 600 NW2d 630, 633, n.5 (1999). The Court reviews questions of law involved in any final order of the WCAC under a de novo standard of review. *Mudel v Great Atlantic and Pacific Tea Co*, 462 Mich 691, 697, n.3; 614 NW2d 607, 610, n.3 (2000).

Pursuant to the holding of this Court in *Michigan Educational Employees Mutual Ins Co v Morris*, 460 Mich 180; 596 NW2d 142 (1999), a no-fault insurer has a valid equitable claim for unjust enrichment against the no-fault insured under circumstances where the no-fault insurer was required to pay no-fault benefits on behalf of the insured, and it is later determined that the benefits were not in fact owing. 460 Mich at 197-198.[2] See, for example, *McCain v Auto-Owners Ins Co* (on rehearing), 223 Mich App 327 (1997), where the Court of Appeals upheld summary disposition in favor of the no-fault insurer and against the no-fault insured for reimbursement of overpayments of no-fault benefits due to retroactive setoff of after-acquired worker's compensation benefits.

In the instant case, it would have been possible for the no-fault insurer to have requested that the bureau determine only the issue of work-relatedness and, upon obtaining a determination that the injury arose out of the employment, to file a circuit court unjust enrichment action against the employee with the employee presumably filing a worker's compensation claim against Amoco. Admittedly, such a complicated series of actions and claims would be subject to a confusing set of time limitations, equitable

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[2]The Court in *Meemic* further noted that since the claim of the no-fault insurer is equitable in nature, the insurer may under certain circumstances be estopped from demanding reimbursement if the insured carries his or her burden of proof that reimbursement would be inequitable due to detrimental reliance or other equitable factors.

defense issues, and shared jurisdiction issues. Nevertheless, it would be a legally valid potential result that the no-fault insured would be found liable to the no-fault insurer for the full amount of the reasonable medical expenses paid by the no-fault insurer and the worker's compensation insurer found liable to reimburse the employee's full reasonable medical expenses pursuant to § 315(1) of the WDCA and 2000 AACS R418.10104.

Other than the fact that the no-fault insurer which honored its obligations would receive full reimbursement, the possible procedural scenario outlined in this section has no conceivable advantage over a direct subrogation action. The alterative scenario involves three claims instead of one, involves the insured to no purpose in a dispute which is properly a dispute between the insurers, consumes the time and energy of the parties and the administrative and judicial tribunals involved, and because of its complexity is fraught with uncertainty. The very purpose of an equitable subrogation action is to cut through these pointless technicalities which give the art of jurisprudence a bad name. "Equitable subrogation is a flexible elastic doctrine of equity... Its application 'should and must proceed on the case-by-case analysis characteristic of equity jurisprudence.'" *Used Car Factory*, 461 Mich at 215. Furthermore, there is dispositive authority in the prior decisions of this Court and the Michigan Court of Appeals that Auto-Owners had an equitable subrogation

claim against Amoco for the full amount of the reasonable medical expenses paid by Auto-Owners and that the worker's compensation bureau has jurisdiction under § 841 to grant and determine such a claim in the full amount of the reasonable medical expenses paid.

VI. The Language of § 315(1) Itself Empowers the Magistrate to Order That Reimbursement for Reasonable Medical Expenses Be Made on Behalf of the Employee to Persons Who Paid the Reasonable Medical Expenses

Standard of Review: An issue of statutory construction is reviewed de novo as a question of law. *Brown v Michigan Health Care Corp*, 463 Mich 368, 374; 617 NW2d 301 (2000).

Although the right of the no-fault insurer to reimbursement for reasonable medical expenses paid is independent of the language of § 315, by operation of the doctrine of equitable subrogation, the language of § 315(1) itself recognizes that the magistrate may order that payment of reasonable medical expenses be made on behalf of the employee to third-parties to whom the unpaid expenses may be owing.

In this connection, § 315(1) provides in relevant part: "If the employee fails, neglects, or refuses [to pay the employee's medical expenses], the employee shall be reimbursed for the reasonable expenses paid by the employee or **payment may be made in behalf of the employee to persons to whom the unpaid expenses may be owing, by order of the worker's compensation magistrate.**" [emphasis supplied].

A plain English construction of this statute is that the word "payment" after the disjunction "or" refers back to the "reasonable expense" in the first clause. Further, the second clause of this disjunction uses the phrase "to persons to whom the unpaid expenses may be owing" instead of a narrower construction, such as "to the health care provider who provided the services." The language of the second clause is broad enough to include third-parties who pay the original health care provider and thereby become "persons to whom the unpaid expenses may be owing."

It is true that the WCAC and the magistrate did not adopt the construction of § 315(1) advocated here. However, "an agency interpretation cannot overcome the plain meaning of a statute." *Consumers Power Co v Public Service Commission*, 460 Mich 158, 167, n.8; 596 NW2d 126 (1999).

The plain meaning of § 315(1) is that the magistrate may order reimbursement of reasonable medical expenses paid by third-parties on behalf of the employee.

RELIEF REQUESTED

Plaintiff-appellant Auto-Owners Insurance Company requests that the decisions of the Court of Appeals, the Worker's Compensation Appellate Commission and the Worker's Compensation Magistrate be reversed and that Auto-Owners be determined to be entitled to be reimbursed for all reasonable medical expenses paid on behalf of Leroy Smithingell for injuries determined by the

Magistrate, Appellate Commission and the Court of Appeals to have arisen out of his employment irrespective of the charge limitations set forth in the Worker's Compensation Health Care Services Rules. Plaintiff-appellant Auto-Owners further requests that the case be remanded to the WCAC for a determination of the current amount of medical expenses paid by Auto-Owners.

Dated: June 21, 2002

WHEELER UPHAM, P.C.

By: _____

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